

**STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL
LICENSING
APPLICATION FOR LICENSURE**

**CERTIFIED PROFESSIONAL COUNSELOR INTERN,
PROFESSIONAL COUNSELOR**

DOPL-AP-067 REV 03/30/2001

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents and fees.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply all necessary information may result in denial of licensure. Please read all instructions carefully.

Address Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Also, please note, the address of record is public information, available upon request and via the internet. You may choose to use a business address or a P.O. Box for your address of record rather than your home address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann, which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

Supporting Documents and Fees:

1. If you are applying for licensure as a Certified Professional Counselor Intern, submit the following documents and fees.
 - ☐ Submit official college transcript(s) documenting your graduate degree in a counseling program which meets the requirements of Statute and Rules, as well as any other official transcripts that are necessary to document completion of specific course work.

Request that the school(s) submit this documentation to you to be included with your request.

Attach a course description and other pertinent information for any course which is not adequately described by the title shown on the transcript. You can expedite the review process by providing a copy of the graduate catalog course description and/or syllabus of any identified courses.

- ❑ Submit the \$75.00 non-refundable application fee for a Certified Professional Counselor Intern.

2. If you are applying for licensure as a Professional Counselor, submit the following documents and fees.

- ❑ Submit official college transcript(s) documenting your graduate degree in a counseling program which meets the requirements of statute and rules, as well as the completion of specific course work.

Request that the school(s) submit this documentation to you to be included with your application.

- ❑ Submit a completed “Verification of Supervised Experience” form from each of your supervisors to document a total of 4,000 hours of supervised experience, 1,000 hours of which are in Mental Health Therapy.

Request that each supervisor submit a form to you for submission with the remainder of your application.

- ❑ Submit the letter from Exporior documenting your passing score on the Utah Professional Counselor Law, Rules, and Ethics Examination.
- ❑ Submit the verification of your passing score on the National Counseling Examination.
- ❑ Submit the verification of your passing score on the National Clinical Mental Health Counseling Examination.
- ❑ Using the “Request for Verification of License” form, obtain verification of licensure from each state in which you are currently licensed as a professional counselor.

Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

- ❑ Submit the \$75.00 non-refundable application processing fee for a Professional Counselor License.

3. If you are applying for licensure by endorsement (current licensure in another state), submit

the following documents and fees.

- ❑ Using the “Request For Verification of License” form, obtain verification of licensure from every state in which you are currently licensed as a professional counselor.

Request that the verifying state(s) complete the form(s) and mail or fax them directly to the Division or return them to you for submission with your application.

- ❑ The letter from Experior with your passing score on the Utah Professional Counselor Law, Rules, & Ethics Examination.
- ❑ Documentation showing that you have been actively engaged in the lawful practice of professional counseling including mental health therapy for not less than 4,000 hours during the three years immediately preceding the application for licensure in Utah.
- ❑ The \$75.00 non-refundable application processing fee for a Professional Counselor License.

Additional Important Information:

1. **Law and Rules Exam:** Applicants for licensure as a professional counselor must pass the Utah Professional Counselor Law, Rules, and Ethics Examination. Contact Experior at the address and telephone below to register for the law examination.

Experior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009.

You may also purchase a study guide from Experior, which has been prepared to assist candidates taking law exams.

In addition, the following applicable laws and rules are available on the Internet at <http://www.commerce.state.ut.us/DOPL/dopl1.htm>

- ❑ Division of Occupational & Professional Licensing Act
- ❑ General Rules of the Division of Occupational & Professional Licensing
- ❑ Mental Health Professional Practice Act
- ❑ Mental Health Professional Practice Act Rules
- ❑ Professional Counselor Licensing Act Rules

2. **“Practice of mental health therapy”** means treatment or prevention of mental illness, including:

- ❑ conducting a professional evaluation of an individual’s condition of mental health, mental illness, or emotional disorder;
- ❑ establishing a diagnosis in accordance with established written standards generally recognized in the professions of mental health therapy;
- ❑ prescribing a plan for the prevention or treatment of a condition of mental illness or

emotional disorder; and

- ❑ engaging in the conduct of professional intervention, including psychotherapy by the application of established methods and procedures generally recognized in the professions of mental health therapy.

3. **Requirements For A Mental Health Therapy Supervisor:** In order for an individual to be qualified as a Certified Professional Counselor Intern supervisor, the individual shall be currently licensed and in good standing as either a professional counselor, psychiatrist, psychologist, clinical social worker, registered psychiatric mental health nurse specialist or marriage and family therapist. He/she shall have engaged in the lawful practice as a licensee engaged in the practice of mental health therapy for a period of two years prior to beginning supervision activities. A mental health therapy supervisor can supervise not more than three supervisees at any given time unless approved by the board and division.
4. **Supervised Professional Counselor and Mental Health Therapy Experience:** Upon completion of the required education, 4000 hours of supervised professional counselor and mental health therapy experience is required for licensure. This experience must be obtained while holding the Certified Professional Counselor Intern license. The “Verification of Supervised Experience” form must be submitted upon completion of the required supervised experience.
5. **Supervised Experience in Mental Health Therapy:** The 4000 hours of supervised professional counselor experience includes a minimum of 1000 hours of supervised experience in mental health therapy. You must also document 100 hours of face-to-face supervision.
6. **Change in statute** – requirement to be licensed while obtaining qualifying experience. Prior to May 1, 2001, a person could (based upon an exemption) obtain qualifying experience without holding a license but only after they completed their education requirement and meeting certain other requirements. Beginning May 1, 2001, qualifying experience for the Professional Counselor license can only be obtained while a person holds a valid Certified Professional Counselor Intern license.
7. **Transcripts:** If your education has been previously approved by the Division, either through a course work review or other approval by the Division, you do not need to complete the Educational Requirements section but must submit a copy of the approval letter from the Division.
8. **Examinations:** To obtain information regarding the National Counseling Examination, the National Clinical Mental Health Counseling Examination, or the Utah Professional Counselor Law, Rules, and Ethics Examination, you may contact Exporior at the address and telephone number above.
9. **Endorsement:** To qualify for licensure by endorsement (licensure in another state), an applicant must document that he/she is currently licensed in good standing in another state

and has been actively engaged in the lawful practice of professional counseling including mental health therapy for not less than 4,000 hours during the three years immediately preceding the application for licensure in Utah. The applicant for licensure by endorsement must also document a passing score of the Utah Professional Counselor Law, Rules, and Ethics Examination.

10. **Continuing Education:** Forty (40) hours of continuing education is required for each two year period. This requirement is pro rated for new licensees.
11. **License Renewal:**
 - a. The Certified Professional Counselor Intern license is issued for a period of three years. It is generally expected that you will complete the 4000 hours of supervised experience during that time period and become licensed as a Professional Counselor. This license will not be renewable unless the individual presents satisfactory evidence to the division and board that reasonable progress is being made toward passing the qualifying examinations or is otherwise on a course reasonably expected to lead to licensure, but the period of the extension may not exceed two years past the date the minimum supervised experience requirement has been completed.
 - b. The Professional Counselor license is renewed on September 30th of even-numbered years.
12. **Examination Fees:** There are separate fees for all examinations. It is the responsibility of the applicant to submit the fees directly to the testing agency.
13. Applications, laws and rules may change from time to time. If you have not recently obtained any of these documents, you may want to contact the Division to verify that you have a current document.

Make Licensure Fees Payable To:

DOPL

Mail Complete Application To:

By U.S. Mail

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

Telephone Numbers:

Direct Dial: (801) 530-6727
(801) 530-6163

Utah Toll Free: (866) ASK-DOPL
(866) 275-3675

Fax Number: (801) 530-6511

APPLICATION FOR LICENSE or CERTIFICATE or REGISTRATION

GENERAL INFORMATION

License/Certificate/Registration Applying For: _____

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Have You Ever Held A Utah License Before? Yes _____ No _____

If Yes, Name of Profession: _____

If Yes, License Number: _____

Gender (Male or Female): _____ Date of Birth: _____

PUBLIC MAILING ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

County: _____

Telephone: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: _____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

APPLICATION FOR:

_____ Certified Professional Counselor Intern

_____ Professional Counselor

EDUCATION REQUIREMENT (Attach additional sheets if necessary):

1. Name: _____ Dates Attended: _____ To _____

Location: _____

Degree Received _____ Date of Graduation: _____

2. Name: _____ Dates Attended: _____ To _____

Location: _____

Degree Received: _____ Date of Graduation: _____

EXAMINATION REQUIREMENT:

Answer "Yes" or "No"

_____ Utah Professional Counselor Law, Rules, and Ethics Exam, Date(s) Taken: _____

_____ National Counseling Exam, Date(s) Taken: _____

_____ National Mental Health Counseling Exam, Date(s) Taken: _____

LICENSES:

List all licenses, registrations, or certifications issued by any state which you now hold or have ever held as a professional counselor. Use additional sheets if necessary.

Issuing State: _____

Profession _____

Issuing State: _____

Profession _____

PROFESSIONAL EMPLOYMENT EXPERIENCE:

List in chronological order your places of supervised professional employment experience totaling

4000 hours of experience. Please show month and year for each. Use additional sheets if necessary.

1. Position: _____ Telephone: _____
Organization: _____
Address: _____
Contact Person: _____
Dates of Employment: _____/_____/_____ to _____/_____/_____
Primary Responsibilities/Activities: _____

of hours providing clinical services per week: _____

2. Position: _____ Telephone: _____
Organization: _____
Address: _____
Contact Person: _____
Dates of Employment: _____/_____/_____ to _____/_____/_____
Primary Responsibilities/Activities: _____

of hours providing clinical services per week: _____

3. Position: _____ Telephone: _____
Organization: _____
Address: _____
Contact Person: _____
Dates of Employment: _____/_____/_____ to _____/_____/_____
Primary Responsibilities/Activities: _____

of hours providing clinical services per week:_____

4. Position: _____Telephone:_____

Organization:_____

Address:_____

Contact Person: _____

Dates of Employment: _____/_____/_____ to _____/_____/_____

Primary Responsibilities/Activities: _____

of hours providing clinical services per week:_____

5. Position: _____Telephone:_____

Organization:_____

Address:_____

Contact Person: _____

Dates of Employment: _____/_____/_____ to _____/_____/_____

Primary Responsibilities/Activities: _____

of hours providing clinical services per week:_____

PROFESSIONAL COUNSELOR QUALIFYING QUESTIONNAIRE

Answer "yes" or "no" for each question. Do not leave any question blank.

1. ____ Have you ever applied for or received a license, certificate, permit or registration to practice in a regulated profession under any name other than the name listed on this application?
2. ____ Have you ever been denied the right to sit for a profession licensure Examination?
3. ____ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
4. ____ Have you ever been permitted to resign or surrender your license, certificate, permit or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency, hospital or other health care facility, professional association, or criminal or administrative jurisdiction?
5. ____ Is any disciplinary action pending against you now by any licensing agency?
6. ____ Have you ever had hospital or other health care facility privileges, or professional association membership denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way?
7. ____ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, professional association membership, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, professional association, or criminal or administrative jurisdiction?
8. ____ Is any action related to your conduct or patient care pending against you now at any hospital, health care facility or agency?
9. ____ Have you had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way?
10. ____ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, professional association, or criminal or administrative jurisdiction?
11. ____ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?

12. ____ Is any action pending against you now by either the federal Drug Enforcement Administration or any state drug enforcement agency?
13. ____ Have you been named as a defendant in a malpractice suit during the past ten years? The filing date of the complaint naming you as a defendant should be considered to be the date of the malpractice suit for purposes of responding to this question.
14. ____ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
15. ____ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
16. ____ If you are licensed in the profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
17. ____ Are you currently using or have you recently used any drugs (including recreational drugs) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
18. ____ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
19. ____ Have you ever been arrested for or charged with a misdemeanor or felony charge in any jurisdiction during the last 10 years? **Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed**, however, minor traffic offenses such as parking or speeding violations need not be listed.
20. ____ Have you ever pled guilty to, no contest to, or been convicted of any felony or misdemeanor in any jurisdiction?

If you answer “yes” to question 19 or 20, you must include with your application, a police report, court docket, and any probation/parole officer report for EACH and EVERY arrest and/or conviction within the past ten years.

21. ____ Have you ever been incarcerated for any reason in any Federal, State or County Correctional Facility?
22. ____ Have you ever been involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

23. _____Have you ever been terminated from a position because of drug use or alcohol?

If you answered “yes” to any of the above questions, please enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A "yes" answer does not necessarily mean the applicant will not be granted a license; however, additional documentation may be requested by the Division if the information submitted is insufficient.

EDUCATIONAL REQUIREMENTS

List **all** of your graduate course work in each of the areas. List each course title **as it appears on your transcript**. Use each course only once.

Ethical Standards and Issues (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Professional Roles and Standards (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Individual Counseling Theory (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Group Counseling Theory (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Human Growth and Development (minimum 6 semester or 9 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Cultural Foundations (minimum 3 semester or 5 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Therapeutic Methods and Interventions (minimum 6 semester or 9 quarter hours.) Total

Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Psychopathology and DSM Classification (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Dysfunctional Behavior (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Test and Measurements Theory (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Advanced Assessment of Mental Status (minimum 2 semester or 3 quarter hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Research and Evaluation (minimum 3 semester or 5 quarter hours - do not use project, thesis, or dissertation hours.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Practicum (minimum 3 semester or 5 quarter hours.) Total Hours:_____

Please describe the setting in which the practicum occurred including:

Placement site: _____

Site supervisor: _____

Site supervisor's license type and license number: _____

Dates of practicum: _____

Number of clock hours: _____

Services provided: _____

Course Title: _____ Course No.: _____ University: _____ Year: _____

Credits (S/Q): _____ Credits Rec'd. _____

Course Title: _____ Course No.: _____ University: _____ Year: _____

Credits (S/Q): _____ Credits Rec'd. _____

Course Title: _____ Course No. : _____ University: _____ Year: _____

Credits (S/Q): _____ Credits Rec'd . _____

Internship (minimum 600 clock hours of supervise experience or 5 years of supervised mental health therapy experience.) Total Hours: _____

Please describe the setting in which the internship occurred including:

Placement site: _____

Site supervisor: _____

Site supervisor's license type and license number: _____

Dates of internship: _____

Number of clock hours: _____

Services provided: _____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd ._____

Other behavioral science courses (if you graduate on or after January 1, 1997, you must complete a minimum of 16 semester or 23 quarter hours of behavioral science electives. Six semester hours of Project, thesis, and dissertation hours may be counted for this area.) Total Hours:_____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd ._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd._____

Course Title:_____ Course No.:_____ University:_____ Year:_____

Credits (S/Q):_____ Credits Rec'd ._____

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division in conjunction with this application or its supporting documents meets the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Applicant: _____

Date of Signature _____

Printed Name of Applicant: _____

Division of Occupational and Professional Licensing
160 East 300 South, P.O.Box 146741
Salt Lake City, Utah 84114-6741
Fax: 801 530-6511

REQUEST FOR VERIFICATION OF LICENSE

TO BE COMPLETED BY THE APPLICANT:

Request that the verifying state complete the form and mail or fax it directly to the Division or return it to you for submission with your application.

Applicant Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

I am requesting licensure in the State of Utah as a _____

I am/have been licensed in your State under the name _____

My Social Security Number is _____

My date of birth is _____

My license number in your State is/was _____

I have enclosed the necessary license verification fee in the amount of \$ _____

Signature of Applicant: _____

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail or fax it directly to the Division or place the completed form in an envelope, seal the envelope and provide it to the applicant in person or by mail. The applicant will include the verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: _____

Name of Licensee (as it appears in verifying state's records): _____

Classification of License Issued: _____

License Number: _____

Current Status: _____

Original Date of Licensure: _____

Expiration Date: _____

Continuously Licensed:

_____ Yes _____ No, please elaborate _____

Licensed By:

_____ Exam, Type: _____ Date: _____

_____ Endorsement, From What State _____

_____ Waiver, _____

_____ Examination Scores: _____

Education Required For Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

_____ No _____ Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: _____

Title: _____

Agency: _____

Date: _____

(SEAL)

Division of Occupational and Professional Licensing
160 East 300 South, P.O.Box 146741
Salt Lake City, Utah 84114-6741
Fax 801 530-6511

VERIFICATION OF SUPERVISED EXPERIENCE

TO BE COMPLETED BY EACH SUPERVISOR OF THE REQUIRED SUPERVISED EXPERIENCE HOURS:

Applicant Name: _____

Supervisor's Name: _____

Supervisor's License issued: State: _____ Profession: _____ Year: _____

Facility Name where experience took place: _____

Facility Street Address: _____

City: _____ State: _____ Zip: _____

Inclusive Dates of Supervised experience: From ____/____/____ To ____/____/____

Total Hours of Professional Counselor experience (min 3000 hours): _____

Total Hours of Experience in Face-to-Face Mental Health Therapy with Clients
(min 1000 hours): _____

Total Hours of Face to Face Supervision (min 100 hours): _____

The hours worked and supervised are reported on the basis of:

____ Supervisor's appointment calendars or records

____ Supervisor's best recollection

Nature of Applicant's Duties: _____

I do hereby certify that the applicant for licensure as a professional counselor has: (check the appropriate line)

_____successfully completed 4000 hours of supervised professional counselor experience which includes 1000 hours of supervised experience in mental health therapy and at least 100 hours of direct personal face to face supervision; or

_____has not successfully completed 4,000 hours of supervised experience.

I further certify that the applicant:

_____is qualified and competent to practice mental health therapy as a licensed professional counselor.

_____is not qualified and competent to practice mental health therapy as a licensed professional counselor.

If applicant is not qualified, please explain the nature of the problem and recommendations for remediation (attach additional pages as needed).

I certify that I am an approved licensed mental health therapist in good standing and I am a qualified supervisor in accordance with Statute and Rules, including having engaged in at least 4000 hours of mental health therapy prior to beginning supervising activities. I further certify that I am professionally responsible for the acts and practices of the applicant which are a part of the required supervised experience.

Signature of Supervisor:_____

Date of Signature:_____